

‘I couldn’t even talk to the patient’: Nursing student-perceived barriers to communicate with cancer patients.

M.-F. Lin, W.-S. Hsu, M.-C. Huang, Y.-H. Su, P. Crawford, C.-C. Tang

Introduction

Communication plays a significant role in health care and is of importance in health education. While evidence has shown the strong relationship between good communication and better patient outcomes including emotional health, symptom resolution, function, physiologic measures, pain control and adherence, miscommunication can result in medical errors, extra financial cost and negative attitude of health care providers (Fallowfield & Jenkins, 1999; Frydenberg & Brekke, 2012; Griffey & Bohan, 2006; Stewart, 1995; Thorne, Bultz, & Baile, 2005). However, health communication can be particularly challenging in cancer care given the fact that cancer is closely linked to poor prognosis, limited curative choices and increased emotion (Kruijver, Kerkstra, Bensing, & van de Wiel, 2000; Lichtman, Taylor, & Wood, 1988; Thorne et al., 2005; Thorne, Harris, Mahoney, Con, & McGuinness, 2004). Furthermore, studies pointed out that a considerable portion of cancer patients are not satisfied with the overall communication process with nurses (Nayak et al., 2005; Suominen, Leino-Kilpi, & Laippala, 1995). Nursing experts tried to address these communication issues by designing and delivering communication training for nurses and nursing students, however, there is no consensus on essential content and outcomes of training. Very little research has explored nursing students’ communication experience with cancer patients, especially their own emotion reaction.

In addition to the aforementioned communication challenges, student nurses encountered other unique tasks when communicating with cancer patients and families. Although there is limited evidence, researchers indicated that these tasks may be related to status, power,

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knowledge and skills and culture. First, nursing students are in a lower status with less power in the medical environment. Consequently, they often feel oppressed, lacking courage and power in the clinical situation (Kav, Citak, Akman, & Erdemir, 2013; Yeh, Wu, & Che, 2010). Second, students are overwhelmed with their clinical responsibilities to utilize the therapeutic communication skills (Sheu, Lin, & Hwang, 2002; Sheu & Mu, 2009; Thomas & Burk, 2009). Third, while culture and health cannot be separated (Helman, 2007), nursing students in eastern culture experienced special cultural concerns when communicating with cancer patients and families. These culture related issues include family centered care pattern, attitude toward truth telling and decision making and end-of-life care preferences (Kagawa-Singer & Blackhall, 2001; Sung, 1991). Another important concept regarding interacting with cancer patients is emotion labor. Emotional labor was first defined by Hochschild (1983) as "the management of feeling to create a publicly observable facial and bodily display" in sociology (Hochschild, 2012). The regulation of emotion requires effort and training and is considered as professional necessity for nursing. Emotional labor is linked to the quality of communication, interpersonal relationship and nursing care (Gray, 2009; Mark & Mann, 2005). Nevertheless, emotional labor received insufficient attention in studies and education addressed health communication.

Understanding student nurses' perceptions and experiences is a necessity for providing appropriate communication training and oncology education (Chant, Jenkinson, Randle, & Russell, 2002). This study seeks to explore communication barriers with emotional-laden response encountered by Taiwanese senior nursing students when caring for cancer patients.

Methods

This qualitative study employed focus group interviews to collect data. Content analysis

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using Nvivo 2.0 software was applied to reveal communication experiences of nursing students when interacting with cancer patients and their families.

Participants

Senior nursing students who had completed the education in basic communication skills and participated in clinical practice required by fundamental nursing, maternal-child nursing, and adult nursing courses were recruited from 3 baccalaureate nursing programs in Taiwan. The inclusion criteria was that student participants were required to have cared for cancer patients for at least 48 hours prior to participation.

Data collection

After obtaining IRB approval, participants were recruited for a focus group facilitated by a PHD prepared nurse with expertise in group dynamics and counseling. Eight focus groups, each with 4 to 7 students, were held. Before each group, a demographic questionnaire related to participants’ learning experiences of communication skills was completed. Four open-ended questions were used to stimulate the group discussion (Table 1). Each session was videotaped and lasted 60 to 100 minutes. The facilitator encouraged the participants to express, share and discuss their communication experiences with cancer patients.

Data analysis

The eight transcribed focus-groups were subjected to inductive content analysis by three nurses with experience in qualitative coding (Elo & Kyngäs, 2008). The coders independently read and coded using Nvivo 2.0 software. The initial coding revealed 67 meaningful free nodes

with common qualities or attributes of nursing students' communication experiences with cancer patients. The 67 nodes were grouped into 33 tree codes with similar patterns, and further inducted into 4 major themes with 10 subthemes. Table two presents the example themes, subthemes, tree codes, nodes and narrative. The constant comparison method was applied until coding consensus was reached among the three analysts. The consistency among three coders was 88% and assured by subjecting the data to peer debriefing and confirmation by conducting member checks with 5 participants.

Results

Forty-five students consented to participate in focus groups. In order to maintain respondent confidentiality, the real names of schools and students are not presented in this study. Thirty-eight were female and their age ranged from 20-22 years old (Table 3). Over half of students had read the related communication articles (51%) and had participated in communication courses (64%) before being recruited to this study. Students had experience in clinical practice with patients suffering from gastric cancer, bladder cancer, colon cancer, esophageal cancer, and breast cancer. Seventy-six percent of the students reported that the communication experience with cancer patients was difficult and caused emotional distress.

The four themes revealing communication experiences were disengagement, reluctance, regression and transition. Detailed information and examples of each theme and corresponding subthemes are discussed in the following paragraphs.

Disengagement

Disengagement occurred when nursing students felt blocked and unable to approach cancer

patients. Students could not initiate communication, a behavior which prevented the chance to build a relationship. The theme was generated from two subthemes: escaping and boundary keeping.

Escaping. The terminally ill atmosphere or the interpersonal tension generated by patients' verbal and nonverbal cues hindered students' attempts to approach cancer patients. These factors influenced their confidence and caused hesitation in further communicating with the patient. The tension resulted in a desire to escape from the communication by avoiding the patient.

"He (patient) simply briefly answered; eyes closed, and waved his hands asking me to leave... I felt embarrassed... since then, I was afraid to approach him...afraid of being rejected again." (A012)

"I didn't feel comfortable entering into oncology wards... the depressing atmosphere... and the sight of my hepatica cancer patient with his mouth half opened and being so fragile... I just want to run away." (C008)

"I felt uncomfortable to open a discussion to sexual issues; particularly patient was such an elderly person that I did not know how to start...." (B014)

Boundary keeping. Family plays an important and unique role in caring for patients in Asian culture. The social norms regarding the power and obligations of taking care of illness in the family greatly affect family's attitude toward care and communication and health care provider's practice. Students must cope with negative displays of this kind of power or authority. In these circumstances, students' first attempts at communication were

marginalized by these boundaries.

“The nurse aid answered the question I asked the patient as if she was the representative. Then she changed the topic without noticing the patient was trying to say something slowly. I couldn’t even talk to the patient”. (A005)

“Due to frequent vomiting, my patient won’t take the medicine. She only waved her hands to express her refusal... However, her families strongly insisted that she takes the medicine... I disagreed with the families since it’s against the patient’s will but I didn’t know how to explain it and persuade the family not to force her again.” (B013)

Reluctance

As nursing students endeavored to initiate communication to build relationships with cancer patients, they were rejected. Patients and families thought students were too young to understand their situation or withdrew despite student’s behaviors. Students were barred in achieving a therapeutic relationship. Students adopted a passive mode, awaited acceptance and were reluctant to communicate. Two subthemes were identified: devaluation and rejection.

Devaluation. Students experienced being treated as novices by patients or families who prevented student involvement in nursing interventions. The students expressed feelings of being devalued as unskilled or untrustworthy.

“He shrugged my hands off with an unfriendly attitude as though I was not qualified to take care of him.”(A001)

“I felt so scared of the family; she always kept watching me while I did every step of

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care for the patient.” (C002)

“The forty something male patient was positive but had fear of physical pain. He would not let me change the wound dressing because of my gender and age. And I did not have much communication with him after that. ” (B003)

Rejection. Nursing students faced patients’ or families’ explicit rejection. The rejection resulted in discouraging further communication. The patient-student relationship was undermined with some families claiming dissatisfaction with the interaction.

“He lay on the bed, seemed so moody and put arms on the chest with eyes closed. He did not want to talk at all while I stood beside his bed for a while. Then the accompanied person said that you just go out and do not talk to him today.” (B014)

“The cancer patient was receiving the 3rd or 4th course of chemotherapy, he seemed to know about the treatment more than I did. He refused my hands on him with a bad attitude. In his opinion, my care for him was unnecessary.”(C014)

Regression

While students had established superficial relationships using basic communication skills, nevertheless, they encountered other barriers to communication. Difficulties in applying advanced skills or patients’ negative perceptions hindered students from further understanding patients’ concerns or providing emotional support. Three subthemes were identified: disconnectedness, passivity and avoidance.

Disconnectedness. Students had been equipped with basic communication skills, however,

in the clinical environment, they struggled to perform and failed to achieve an understanding with patients. The student-patient relationship fluctuated as students were unsuccessful communicating despite their self-expectations of success. Although students had learned that phrases such as “cheer up” would not be helpful in comforting patients, they could not help but use such statements to avoid embarrassment. Such inappropriate communication resulted in a seeming disconnect between students and patients. Students were incapable to probe or direct focused communication when patients tried to change topics.

“When families asked me ‘this disease is serious, right?’ I didn’t know how to answer, especially in front of the patient... so I said something impractical trying to give them some hope.” (B012)

“I couldn’t guide the patient to disclose her inner feelings to me. Sometimes she answered my question briefly and sometimes she just shifted the topic. While I tried to discuss the issue of intimacy and sexual relationships after a mastectomy, it was ignored by her.” (A008)

Fear of losing control. While encountering the emotion-laden responses of patients or family members, students were frightened and worried about losing control of such situations. Students tended to view patient’s crying as a negative behavior which triggered student uneasiness and self-blame. Students reflected that they had failed to perceive patients’ psychological cues and needs for comfort and reassurance. As a result, students struggled to provide care and passively responded.

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“I’m afraid of losing control of the situation if I do something. While receiving the diagnosis result, the patient’s wife cried... they seemed to lose hope in life. I didn’t know how to comfort them, couldn’t find out the words to say... I felt sad.”(B006)

“It was so tough at that time when the patient was not informed of his diagnosis. He cried out after knowing the bad news and I also cried for not knowing how to soothe him.” (A010)

“Only if I insisted then she replied simply and then silently. I took care of her for 3 weeks but I do not think that we had a therapeutic relationship. I had no idea how to improve this; I felt that I may need to give up the hope....” (C013)

Avoiding a taboo. Students recognized speaking about death in Taiwan is a controversial taboo which made communication about terminal illness difficult. Nursing students with limited end-of-life care experiences encountered complex barriers around denial or unpreparedness in relation to a terminal diagnosis. As such, death became a hidden agenda between patients and students.

“It was difficult to approach his inner world. He was in the terminal cancer stage and no one accompanied him. It’s challenging for me to connect with him.”(C009)

“The patient didn’t talk much under the oppressing atmosphere around the room. It forced us to leave immediately after finishing the routine work since we couldn’t start a conversation about death.”(C004)

A cancer patient said: “I am not going to die...you all want to watch me die!...” when

he mentioned the topic about “die” I just did not know how to deal with it.... (A011)

Transition

Students improved their communication skills by identifying previous communication barriers and failures. They were able to conduct in depth conversations with patients while encountering some challenging situations; however, they remained over-sensitive to patients’ perception of them in the aftermath of previous unsatisfactory interactions. Three subthemes were derived: dilemma, incapability and carefulness.

Dilemma. Students were hesitant in dealing with the ambivalent situations including breaking bad news or telling the truth. In the Taiwanese culture, most families insist that patients are too vulnerable to receive bad news and choose to hide the prognosis from patients. Wishing to respect families’ decisions conflicted with notions of patient-centered care and created a dilemma in nursing students. One student reported that when families requested that she conceal the diagnosis, she was anxious about the assigned task and cautious about her conversations with the patient.

“A woman with breast cancer had not disclosed her disease to her children, which made me worry about the possible negative impacts on the kids afterwards. However, she insisted in not telling... I didn’t know what I should do.”(C005)

“Some families do not want to let the patients know their condition, I felt helpless due to my limited caring experience... I had no idea what I should or shouldn’t say. My mentor even expected me to figure out how much the patient knows, which made me scared. I was afraid to spill out the truth to the patient.”(A013)

Incapability. Students considered the possible negative impact on patients during direct communication about patients' diagnosis and problems. Their self-reflection barriers and cautiousness impeded continuous communication and care. Students expressed frustration about their inability to help patients solve problems.

"After talking to them, I found that they had lots of problems that should be solved. My inability to help them made me feel depressed." (C014)

"I wanted to help but was afraid to hurt the patients. I intended to ask my former patient the differences between before and after surgery or his emotion. But I held back. I felt restricted and was concerned about my expression and questions." (B008)

Asking for the best. Nursing students cautiously modified their communication style with patients following previous ineffective interactions. In response to frustrating experiences, students tried to solve problems and figure out how best to proceed. For example, when they observed that their communication resulted in patient displeasure, they tried to remedy the situation by fulfilling patients' needs and soliciting a more favorable impression.

The first time I changed her dressing comparatively slower than others, she was unhappy due to the pain of the wound. I told her that I'd do it faster in order to avoid hurting her tomorrow. I kept my promise, and she returned her gratitude cheerfully with a thumb-up. (C012)

I discovered lots of problems from communication. I would feel quite powerless when I could not solve those problems in this week since her life countdown. (A009)

Discussion

To our knowledge, this is the first study explored communication experience with cancer patients from the nursing students' perspectives in Taiwan. By identifying four themes: disengagement, reluctance, regression and transition, this study delineated a range of experiences regarding nursing students' interaction with hospitalized cancer patients and families. These barriers diminished nursing students' confidence to initiate and maintain a therapeutic relationship with cancer patients. As a result, nursing students were passive, afraid and oversensitive during communication. They became hesitant and self-conscious while, at the same time, struggle to overcome the barriers and develop strategies for enhanced communication. Based on our findings, students' communication barriers may associate with multiple, interrelated factors, such as insufficient training, low self-efficacy, poor emotional regulation, student identity and special culture care model.

Insufficient training about communication skills

Although about half of the participated students had some forms of communication training, the majority of the students mentioned the gap between knowledge and practice as described in the theme of transition. This insufficiency in communication training and knowledge gap matches findings from a literature review (Chant et al., 2002). Furthermore, while the other half of the students did not receive any formal cancer communication training, the clinical placement forced them to interact with vulnerable cancer patients and families with special communication considerations and needs. Disengagement was the initial obstacle when students tried to maintain clear boundaries between themselves and cancer patients. Their initial communication attempts ended in interpersonal stagnation which is consistent with a prior study in medical students, Lin

and colleagues (2001) found that opening and approaching skills were the major difficulties for medical students (Lin, Barley, & Cifuentes, 2001). With the unsuccessful opening, some students flee from the conversation which was similar to Hjörleifsdóttir and Carter's finding (Hjörleifsdóttir & Carter, 2000). Like registered nurses and medical students, nursing students also experienced communication difficulties regarding special conditions, such as delivering bad news (Malloy, Virani, Kelly, & Munévar, 2010; Supiot & Bonnaud-Antignac, 2008). Nursing students felt trapped in a position between patient autonomy, medical paternalism and family protectionism (Sheu, Huang, Tang, & Huang, 2006). Our findings suggest that nurses sensed and experienced these communication difficulties early in their career. Addressing these communication issues early in the student stage may be more appropriate as they are forming their professional identities and establish communication style.

Insufficient training of communication knowledge and skills may be the most obvious and universal problem, however, it is just one cause of ineffective communication. As our findings revealed a wide variation of nursing students' communication experiences from totally blocked (disengagement) to conducting more effective communication (transition), we found that the blocked status (e.g., disengagement and reluctance) is more relevant to students' emotional regulation, power status and culture consideration than communication knowledge and skills. In other words, students needed to effectively regular their emotion before using their cancer communication knowledge and skills. However, emotional regulation seems to receive less attention in studies looked at health communication.

Poor emotional regulation

Our findings showed that student nurses had a hard time to regulate patients and self's

emotion. As described in the themes of disengagement, reluctance and regression, students tended to escape and avoid emotional situations. They had significant emotion fluctuation when being devaluated or rejected by the patients, nursing aids or families and had a fear of losing control. These feelings plus their perceived topic severity (e.g., death as a taboo issue) and low efficacy impeded students probing and achieving deeper mutual understanding. This finding supports other study results which revealed nursing students' fear of handling emotion and their usage of blocking or distancing strategies in Turkey and the United Kingdom (Kav et al., 2013; King-Okoye & Arber, 2014). Moreover, consider the different performance level of emotional regulation, our findings indicated that students regulated their emotion at a more surface, response-focused level (e.g., escaping from the emotional situation based on patients or families' negative response) rather than at a deep, antecedent-focused level (Mark & Mann, 2005).

Emotional regulation may associate with several factors such as gender and identity (Gray, 2009; Mark & Mann, 2005). Given the fact that both student identify and female gender are related to lower power status, students may need to regulate emotions with these external interferences. Specifically, in the theme of reluctance, students mentioned how patient distrusted them as inexperience care providers. This negative feedback then contributed to students' negative emotions. The lower power status and public's perception of nursing students may not only negatively affect students' emotion but also pose more challenges to the process of role transition. What our students described about perceiving devaluation and rejection coincides with the prejudice experienced by students from patients or families in terms of their gender, youth, and social status (Hjörleifsdóttir & Carter, 2000; Suikkala & Leino-Kilpi, 2001). In summary, echoing other researchers, our findings demonstrated that emotional labor is an essential part when communicating with patients and needs to be addressed early in nursing education (King-

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Okoye & Arber, 2014; Smith, 1991). Researchers and educators need to explore students’ perception of emotional labor in order to provide support.

Culture considerations

Compared to most western culture, health care and communication in other cultures, such as Japan, China and Mexico, is more family focused (Frank et al., 2002; Harris & Long, 1999; Hicks & Lam, 1999). In these cultures, family caregivers believe that they have the responsibility to protect the patients by filtering the information and assisting with making decisions (Frank et al., 2002). Similarly, family caregivers are allowed and expected to provide bedside care and participate in communication and decision making in Taiwan. Some Taiwanese families hire nurse aids for bedside care (Lin, 2000; Sung, Chang, & Tsai, 2005) that may have more experience and familiarity with cancer patients than nursing students. Similar to other Taiwanese studies which pointed out that families perceived themselves as decision-makers and gatekeepers who are ethically responsible to safeguard their vulnerable members (Fan & Li, 2004; Lin, 2000; Sheu et al., 2006), our subtheme of boundary keeping delineated how family caregivers participate in or even dominated the communication in order to protect patients. As they perceived student nurses as inexperienced health care providers, they tended to take a lead in the patient-student conversations. It is important for educators and students to understand the meanings and health believe behind this family dominant conversation.

While involving families in patient care is particularly important for family-centered care model, understanding and responding to families’ needs and emotions is always challenging, especially for students, when caring for terminally ill patients worldwide (Charalambous & Kaite, 2013; Huang, Chang, Sun, & Ma, 2010; Sanford, Townsend-Rocchiccioli, Quiett, &

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3 Trimm, 2011). Our findings showed the importance of preparing students to communicate and
4 recognize families' concerns and needs before assigning them to terminally ill patients. Whereas
5 the majority of text books and caring models were developed and tested in western culture with
6 individual focus, our findings pointed out the importance of developing culturally appropriate
7 care and education.
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16 Early and comprehensive communication training is imperative. In the short term, it can
17 reduce the pressure of working in an oncology setting which can frustrate students and drain
18 their energy (Basso Musso et al., 2008). For the long term, it can enhances students' positive
19 clinical experience which is positively related to future job satisfaction (Wu & Norman, 2006).
20 Adequate communication training for nursing students thus has the potential to promote positive
21 nurse-patient relationship and enhance nurse retention.
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32 **Conclusion**

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35 The findings of the current study provide a deeper understanding of nursing students'
36 communication experiences in Taiwanese oncology settings, advancing further insights into the
37 progress from novice to qualified nurse. Unfortunately, our results did reveal that students had
38 traumatic communication experience which prohibited them from establishing effective
39 communication with cancer patients. Lack of preparations, including communication knowledge,
40 skills and emotional regulation, before the clinical placement in cancer settings contribute to
41 nursing students' negative communication experiences. Special communication training
42 programs targeting patient populations with different needs and considerations may be necessary
43 for nursing students or novice nurses who will take care of unfamiliar patient populations.
44 Culture specific considerations, such as families' protecting behavior should be identified and
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discussed openly. Ideally, educators and clinical preceptors need to communicate with and educate families before assigning students to the patients. Other strategies such as role play, case scenarios or exposure in a less stressful environment are recommended to enhance students' self-efficacy (Sanford et al., 2011). Examples from the current study (e.g., reluctance or regression scenarios) can be used as cases to raise awareness or facilitate discussion.

Identifying emotional reactions and regulating emotions adequately are important abilities when communicating with vulnerable patients and families. This can be trained by guiding students to recognize and express their communication experience and feelings through reflective journals or small group discussion. As emotional labor obtains relatively less attention in studies addressing communication education, future studies are needed to examine the relationship among health care students' emotional regulation, communication ability and communication outcomes.

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For Peer Review

Table 1. The interview guide for focus groups.

1.	Do you think communication is important when caring for cancer patients? Why?
2.	Please share some positive examples of patient-nurse communications which you have observed or gone through yourself while taking care of cancer patients.
3.	Please describe the communication problems that you have encountered in the past. And tell us when, where and with whom you try to communicate?
4.	What were the possible reasons that caused your communication problems?

Table 2. Example themes, subthemes, tree codes, nodes and narrative

Theme	Sub-theme	Tree code	Node	Narrative
Disengagement	Boundary keeping	Being interrupted by nurse aid	Private nurse aid ignored patient's attempt of communication by answering questions for patient	<i>The private nurse aid answered the question I asked the patient as if she was the representative. Then she changed the topic without noticing the patient was trying to say something slowly. I couldn't even talk to the patient</i>
Reluctance	Devaluation	Fear of being monitored	Fear of being monitored by family members when cared patient	<i>I felt so scared of the family; she just kept watching me while I did the every step of care for patient all the time</i>
Rejection	Fear of	Fear of losing	Feel afraid and sad as being	<i>I'm afraid of losing control of the situation if I do</i>

	losing control	control due to patient's and family's psychological reactions	unable to manage patient's and family's psychological reactions	<i>something. While receiving the diagnosis result, the patient's wife cried... they seemed to lose hope in life. I didn't know how to comfort them, couldn't find out the words to say... I felt sad.</i>
Transition	Asking for the best	Sensitive to patient's response	Sensed patient's negative emotion; and improved patient's satisfaction by discussed and provided solutions to the problem	<i>The first time I changed her dressing comparatively slower than others, she was unhappy due to the pain of the wound. I told her that I'd do it faster in order to avoid hurting her tomorrow. I kept my promise, and she returned her gratitude cheerfully with a thumb-up.</i>

Table 3. Participants' characteristics (n=45)

Items		N (%)
Age range	20-22 years	
Gender	Male	7 (16%)
	Female	38 (84%)
University	A	15 (33%)
	B	14 (31%)
	C	16 (36%)